MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Positive Pain Management, Inc. 2301 Forest Lane, Suite 310 Garland TX 75042	MDR Tracking No.: M4-03-7101-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 14 Farmers Ins.Exchange c/o Wilson Grosenheider & Jacobs 6836 Austin Ctr. Blvd. #280 Austin TX 78731	Date of Injury: Employer's Name: San Miguel Ins. Agency Insurance Carrier's No.: WT003295

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/13/02	**5/17/02**	**97799-CP**	**$6,650.00**	**$0.00**
5/20/02	**5/30/02**	**97799-CP**	**$9,625.00**	**$9.625.00**
5/31/02	**6/10/02**	**97799-CP**	**$9,450.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

"Enclosed are copies of the preauthorization letters, claims and medical records/clinical notes…Zurich preauthorized… #020503-014 (20 days)…we have not received the preauthorization letter for DOS 5/28/02 – 6/10/02…claims… submitted…resubmitted…Until now we have not received any payment or denial EOB…"

PART IV: RESPONDENT'S POSITION SUMMARY

"We have been retained by Farmers Insurance Exchange…Attached is the completed TWCC-60 form Initial Request for Medical Dispute Resolution. Pursuant to rule 133.307(g) we shall await notification…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Requestor nor Respondent submitted any EOB's. Preauthorization was obtained for DOS 5/9/02 – 5/30/02.

The TWCC-60 was received by TWCC-MDR on 5/19/03. The dates of service (DOS) 5/13/02 through 5/17/02, received for review, were not filed timely according to 133.307(d)(1). Therefore, these DOS can not be reviewed further in this Finding and Decision.

The 5/7/02 preauthorization # 020503-014 from Zurich gave written authorization for ten (10) visits of chronic pain management for dates 5/9/02 – 5/30/02. The requestor submitted convincing evidence to substantiate the chronic pain management services billed according to MFG – MGR II, G, therefore, reimbursement is recommended for DOS from 5/20/02 through 5/30/02, amount due $9,625.00.

The remaining DOS, 5/31/02 – 6/10/02, did not have preauthorization, therefore further reimbursement can not be recommended according to rule 134.600(h)(9)(b).

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/20/2002	97799-CP	$700.00	$700.00				
5/21/2002	97799-CP	$1,400.00	$1,400.00				
5/22/2002	97799-CP	$1,050.00	$1,050.00				
5/23/2002	97799-CP	$1,400.00	$1,400.00				
5/24/2002	97799-CP	$1,225.00	$1,225.00				
5/28/2002	97799-CP	$1,400.00	$1,400.00				
5/29/2002	97799-CP	$1,050.00	$1,050.00				
5/30/2002	97799-CP	$1,400.00	$1,400.00				
						Total Left Column:	$9,625.00
						Total Amount Due:	$9,625.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $9,625.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	James Schneider, Mgr.	2 / 10 / 05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five
days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____